Participant Survey for the Habilitation Supports Waiver

Instructions: Please provide a response to each question. The questions will ask how you are supported to live in the community. Project staff may follow-up at a later date with more questions or may ask to visit with you at your home. This survey should take no longer than 30 minutes to complete.

Note: Your answers will be kept confidential. This means the project staff will not share how you answered the questions. Your answers will be group together with others who complete the survey.

If you have general questions about the survey, contact the Michigan Department of Community Health at HCBSTransition@michigan.gov. If your questions are specific to the Habilitation Supports HCBS Waiver, contact the Habilitation Support Waiver Program at QMP-Federal-Compliance@michigan.gov.

Section 1: Your Information

Name: Click here to enter text.
Home Address (house number and street name): Click here to enter text.
City, State, Zip Code: Click here to enter text.
Phone Number: Click here to enter text.
Email Address: Click here to enter text.

1. What is your Habilitation Waiver Supports Application (WSA) Identification Number?
   Click here to enter text.

   Note: If you don't know this number, ask your Support Coordinator or Case Manager to give it to you.

Section 2: Help to Answer Survey

1. Is someone helping you complete this survey?
   ☐Yes: If marked, answer questions 2 and 3
   ☐No: If marked, go to Section 3: Your Home

2. Who is helping you complete the survey?
   Name: Click here to enter text.
   Contact Phone Number: Click here to enter text.
   Contact Email Address: Click here to enter text.

3. This person is (check all that apply):
   ☐ A family member
   ☐ Your guardian or legal representative
   ☐ Your Supports Coordinator or Case Manager [if checked, answer question 4 of this section]
   ☐ A person that provides your supports (provider agency staff or direct support worker) [if checked, answer question 4 of this section]
   ☐ Other, please specify: Click here to enter text.

4. Support Coordinators, Case Managers, and Support Providers: Please check this box to confirm the person was interviewed to complete this survey. ☐

Section 3: Your Home

1. Where do you live?

I live…	*Do you receive non-residential living supports?*	
☐At home with my family	☐Yes [if checked, jump to section 7]	☐No [if checked, **STOP** the survey]
☐In my home by myself or with my spouse or friends	☐Yes [if checked, jump to section 7]	☐No [if checked, **STOP** the survey]
☐In a specialized residential home	☐Yes [if checked, answer sections 3-7]	☐No [if checked, answer sections survey 3-6]
☐In an adult foster care home	☐Yes [if checked, answer sections 3-7]	☐No [if checked, answer sections survey 3-6]
☐In a private residence that is owned by the PIHP, CMHSP or provider, alone or with spouse	☐Yes [if checked, answer sections 3-7]	☐No [if checked, answer sections survey 3-6]
☐I do not know the answer to these questions.		

2. How would you describe your home?
   ☐Single family home
   ☐Duplex
   ☐Multi-unit or apartment building
   ☐Single residence within complex of unit/apartments for people with disabilities
   ☐Other, please specify: Click here to enter text.
   ☐ I do not know the answer to this question.

3. Who do you live with? (checked all that apply):
   ☐People without disabilities
   ☐People who have disabilities, if checked answer these questions:
      a. How many people with disabilities? Click here to enter text.
      b. Are you related to the people with disabilities you live with?
         ☐Yes
         ☐No

4. Is your home in the same building or on the campus of a treatment center?
   (Note: The definition of a treatment center is in the glossary on the last page of this survey.)
   ☐Yes
   ☐No
   ☐I do not know the answer to this question.

5. Is your home only for people with disabilities?
   ☐Yes
   ☐No
   ☐I do not know the answer to this question.

6. Does your residential provider offer services to people with disabilities in several homes on the same street, nearby streets, or same neighborhood?
   ☐Yes
   ☐No
   ☐I do not know the answer to this question.

7. Do you take school classes at your home or in a building on the campus of your home?
   ☐Yes, If marked: It means you go to school at home or in a building on the campus of your home.
   ☐No
   ☐I do not know the answer to this question.

Section 4: Being Part of Your Community

1. Do you live and/or receive services and supports in a setting where there is regular (more than once per week) opportunity for contact with people not receiving services (e.g. visitors who are friends, family members, others in the larger neighborhood or community)?
   ☐Yes: If marked, answer questions 2, 3, and 4 of this section.
   ☐No: If marked, move to question 5.

2. Who helps you access the community?
   ☐Direct Support Workers
   ☐Home Manager(s)
   ☐Case Manager/Supports Coordinator
   ☐Family/Friends
   ☐Volunteer(s)

3. Which of the following community activities do you choose to do (check all that apply)?
   ☐Shopping for myself
   ☐Religious or spiritual services
   ☐Scheduled appointments (personal or medical)
   ☐Meals with friends or family
   ☐Recreation activities
   ☐Community events
   ☐Volunteer community services
   ☐Community employment
   ☐School or education
   ☐Other: Click here to enter text.

4. Visitors to your home:
   a. Are there rules about visitors, such as visiting hours or times?
      ☐Yes
      ☐No

b. Did the residential provider talk to you about the visitor rules?

☐Yes

☐No

5. Can your Support Coordinator or Case Manager visit when you want them to visit?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

Section 5: Your Rights in Your Home

1. Do you own or lease (rent) your home?
   ☐Own [if checked, **SKIP TO QUESTION 5 of this survey section.**]
   ☐Rent/Lease
   ☐I do not know the answer to this question.

2. Do you have a lease (rental) agreement for your home?
   ☐Yes
   ☐No
   ☐I do not know the answer to this question.

3. Does the lease agreement explain how an eviction happens and what to do?
   (Note: For example, a landlord might tell the renter to move out because the person did not pay their rent.)
   ☐Yes
   ☐No
   ☐I do not know the answer to this question.

4. Do you know how to request new housing?
   ☐Yes
   ☐No

5. Do you have information about your rights when have a CMH plan of supports?
   ☐Yes
   ☐No

6. Do you have information on how to file a complaint about your CMH plan of supports?
   ☐Yes
   ☐No

7. Is the information about filing a complaint in a way you can understand and use it?
   ☐Yes
   ☐No

8. Do you know who to call to file a complaint?
   ☐Yes
   ☐No

9. Do you know how to contact your family members, friends, or guardian when there is a problem?
   ☐Yes
   ☐No

10. Do the staff who help you at home talk your personal issues in front of other people?
    ☐Yes
    ☐No

11. Do the staff who help you at home talk to you using the name you prefer?
    ☐Yes
    ☐No

12. Do you have access to your personal funds?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

13. Do you have control of your personal funds?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

14. Do you have a place to store your belongings away from others?
    ☐Yes
    ☐No

15. Do you pick who provides your services and supports in your home?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

16. Are you able to update or change your services and supports based on your likes/dislikes?
    ☐Yes
    ☐No

17. Are you able to update or change your services and supports based on your needs?
    ☐Yes
    ☐No

18. Do you participate in legal adult activities such as voting in public elections if you are over 18 years old?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

19. Do you have a Positive Behavioral Support Plan that is in writing and just for you?
    ☐Yes: If marked, answer question 20 of this section.
    ☐No: If marked, skip question 20 of this section.
    ☐I do not know the answer to this question.

20. Does the direct care staff use physical restraints in your home?
    ☐Yes
    ☐No

Section 6: Living in Your Home

Decisions About Your Home and Your Privacy

1. Did you pick where you live?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

2. Did you have many choices when deciding where to live?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

3. If you live with other people, did you pick your housemate?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.
    ☐This question does not apply to me. I do not have a housemate.

4. If you live with other people, did you have the option of having your own bedroom?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.
   ☐This question does not apply to me. I do not have a housemate.

5. If you live with other people, did you pcik your roommate?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.
   ☐This question does not apply to me. I do not have a housemate.

6. Are you the only person who has keys or keypad access to your home?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

7. Can you close and lock your bedroom door?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

8. Can you close and lock your bathroom door?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

9. Does your home staff ask before entering your living areas (bedroom, bathroom)?
   ☐Yes
   ☐No: If marked, why?

Meals and Food

10. Do you choose what you eat?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

11. Do you choose if you want to eat alone or with others?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

12. Do you have access to food at any time?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

Clothes and Apparel

13. Do you choose what clothes to wear?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

14. Do you have help with getting dressed if you need it?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

Communication Devices (For example a Cell phone, a Landline phone, a Personal Computer, a Tablet, or an Augmentative and Alternative Communication device)

15. Do you have access to a personal communication device?
    ☐Yes
    ☐No: If marked, why? Click here to enter text. [**SKIP TO QUESTION 19 of this section**]

16. Can you use the communication device in private at any time?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

17. If you share communication device with other individuals you live with, can it be used in a place for private communication?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.
    ☐This question does not apply to me. I do not share a communication device.

18. Does your bedroom have a telephone jack, wireless internet, or an Ethernet jack?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.
    ☐I do not know the answer to this question.

19. Are there cameras, visual monitors, or audio monitors in your home?
    ☐Yes
    ☐No

20. If you need help with personal care, do you receive this support in privacy?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

21. Do you (with or without supports) arrange and control your personal schedule of daily appointments/activities?
    ☐Yes
    ☐No

Freedom of Access in the Your Home

22. Do you have full access to the home's spaces?

Home's Spaces	*Do you have full access?*	*Can you access these spaces at any time?*
Kitchen	☐Yes ☐No	☐Yes ☐No
Dining Area	☐Yes ☐No	☐Yes ☐No
Laundry Area	☐Yes ☐No	☐Yes ☐No
Living Area or Family Room	☐Yes ☐No	☐Yes ☐No

23. If you do not have full access to the home's space, why? Click here to enter text.

24. Is your access to the home's spaces for health and safety reasons in your individual support plan?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.
    ☐This question does not apply to me.

25. Is there space in your home to meet with visitors and have private conversations?
    ☐Yes
    ☐No

26. Can you choose to come and go from your home when you want?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

27. Can you move inside and outside of your home when you want?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

Physical Accessibility of the Home Setting

28. Is your home physically accessible to you? For example does your home have grab bars, shower chairs, or wheelchair ramps if you need it?
    ☐Yes
    ☐No
    ☐This question does not apply to me. I do not need it to live in my home.

29. Are the home's appliances (stove, microwave, etc.) accessible to you?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

30. Is your home free of gates, locked doors, or other ways to block you from entering or exiting certain areas of your home?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

Accessibility of the Community

31. Is accessible transportation available for you to make trips to the community?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

32. If public transit is limited or unavailable, do you have other another way to access the community?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

Section 7: Your Other Supports and Services (Non-Residential Living Supports)

Instructions: In this section, the questions will ask about how you spend your day. This includes the services besides your living supports. In this survey this provider is called, "Your Non-Residential Support Provider".

Note: If you have more than one provider, you will answer questions about each provider.

1. Which of the following do you do?
   ☐I work: If marked answer questions 4-13 of this section.
   ☐I volunteer: If marked answer questions 12-13 of this section.
   ☐I don't work: If marked answer question 13 of this section.
   ☐I go to school: If marked answer question 13 of this section.
   ☐I am retired: If marked answer question 13 of this section.

2. What is the name of Your Non-Residential Supports Provider(s)?
   a) Name of Your Non-Residential Support Provider #1: Click here to enter text.
   b) Name of Your Non-Residential Support Provider #2: Click here to enter text.
   c) Name of Your Non-Residential Support Provider #3: Click here to enter text.
   d) Name of Your Non-Residential Support Provider #4: Click here to enter text.

3. Which of the following do you do? (Mark all that apply)

Non-Residential Living Support	*Location*	*Paid or Unpaid*
☐Supported Employment	☐Disability specific work site (For example, a workshop for people with disabilities, work crew of people with disabilities, etc.) ☐In the community at a local business, restaurant, or as a small business owner	☐Paid ☐Unpaid
☐Out of Home Non-Vocational Services	☐Disability specific work site (For example, a Day Program) ☐ In the community at a local business, restaurant, or as a small business owner	
☐Pre-Vocational Services	☐Disability specific work site (For example, Workshop) ☐ In the community at a local business, restaurant, or as a small business owner	

4. Can you schedule your work hours or days similar to your co-workers who do not have disabilities?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.
   ☐I do not know the answer to this question.

5. Can you schedule your breaks and/or lunch times similar to your co-workers who do not have disabilities?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.
   ☐I do not know the answer to this question.

6. Do you have employee benefits (vacation, medical benefits) similar to your co-workers who do not have disabilities?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.
   ☐I do not know the answer to this question.

7. Do you do work tasks similar to co-workers who do not have disabilities?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.
   ☐I do not know the answer to this question.

8. Do you interact with your co-workers who do not have disabilities?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.
   ☐I volunteer do not know the answer to this question.

9. Do you have contact or connect with individuals from the community/public during work?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.
   ☐I do not know the answer to this question.

10. Do you decide how your work earnings are spent?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.
    ☐I do not know the answer to this question.

11. If you need personal assistance at work or while volunteering, do you receive it in a private, appropriate place?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

12. What other Non-Residential Living Supports do you receive? (Mark all that apply)
    ☐Clubhouse or Peer Operated Support Center
    ☐Integrated Care Organization (ICO) Waiver Day Program
    ☐Peer Mentor
    ☐Peer Support Specialist
    ☐Community Living Supports (CLS): If marked, please specify who provides CLS service:
        ☐Residential Provider
        ☐Vocational Provider
        ☐Pre-Vocational Provider
        ☐Out of Home, Non-Vocational Provider
        ☐Direct Hire or Self-Directed Arrangement
    ☐Other, specify: Click here to enter text.

Glossary

BCAL: Bureau of Children and Adult Licensing

CMHSP: Community Mental Health Service Program

HCBS: Home and Community Based Services

ICO: Integrated Care Organization

IPOS: Individual Plan of Service

PIHP: Pre-paid Inpatient Health Plan

"**As appropriate**": When it is specified in an individual's Personal Safety Plan, Positive Behavior Support Plan, Physician's Orders, or other similar protocol unique to the individual.

Out of Home Non-Vocational Services: Help to gain, keep, or improve your self-help, socialization, or adaptive skills.

Pre-Vocational Services: Include supports, services, and training to prepare a person for paid, integrative community employment or community volunteer opportunities.

Positive Behavioral Support Plan: During the person-centered planning process, it may be learned that a behavior treatment plan is needed to support the individual. The individual or his/her legal representative must give consent before a behavior plan is used. If a plan includes restrictive or intrusive techniques, the plan must be reviewed and approved/disapproved by the local PIHP Behavioral Treatment Committee.

Treatment center: A facility is a place where some or all of these services are provided: group therapy, individual therapy, on-site activities, behavioral support, psychiatric services, nursing supports, and vocational employment/training. The person also lives in the facility or on its property.